

**OFFICE USE ONLY**

Date of Inquiry \_\_\_\_\_In Person Zoom Phone Call

Spoke w/  Mother Father Guardian School Counselor

Email Docs Email Award  Email counselor

 Counselor List  **School District** CH GIL

School Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Jr HS

Grade\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_

 **Grant NMK** $\_\_\_\_\_\_ **LBF Funds** $\_\_\_\_\_\_

Youth Counseling Parent/Child Support

**Laloboy Foundation Intake Form** **Translator Needed\_\_\_\_\_\_\_\_**

# **Mother’s Name**: Address: City Zip

Cellular Phone #: E-mail Address:

**Father’s Name**:

Address: City Zip

Cellular Phone #: E-mail Address:

**How many children and ages?** B/G B/G B/G \_\_\_\_\_B/G \_\_\_\_ Live with you part-time or full-time?\_\_\_\_\_\_\_\_\_\_\_\_\_

 Single Divorce  Married  Other Relatives in the household\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apt Home Special Needs Child Chronic Illness Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_ School Counselor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the Child needing services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_ Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the Child needing services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_ Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## FINANCIAL RESOURCES

Food Stamps ACCHS Ins. WIC  HUD Housing Free/Reduced Lunch

## Health Insurance Information

Insurance Company: Billing Address: City Zip

Name of the Insured: DOB Primary  Secondary

Policy # Group# Counseling service coverage? Yes No Co-pay $

## DEMOGRAPHIC INFORMATION

White Black American Indian/Alaska Native  Asian Native Hawaiin/Other Pacific Islander Hispanic/Latino

## What are some concerns about mental wellness for your child(ren)?

 Depression Anxiety Chronic Illness Autism Blind Hearing Impaired  Child Isolation Drug Addiction

 Suicide Attempt Date:  Sexual Abuse  Safety issue  Suspension from school  Cyberbully issues Yes No Other Medical Diagnosis (don’t need medical records) Has your child(ren) been in counseling before? Yes No

If so, what are the name of the practice and the name of the therapist?

Are both parents in favor of counseling? YesNo Do you have the authority to make medical decisions for your child? Yes No

Are you fully prepared to give your child(ren) the support that they need and follow the instructions of your therapist? Yes No

|  |
| --- |
| **How did you hear about the Laloboy Foundation?** |
| Website  Church  Friend  Counselor  notMykid  Google  School Counselor:  |

**Other resources for families:** Financial Assistance Youth Support Groups Parenting/Youth Workshops

Internet Safety Education Other resources needed for your family

Provide Parenting and Youth Workshops